

## Virtual Anxiety Group Consent Form

I, \_\_\_\_\_ (Name of Parent/Guardian) hereby provide  
consent for \_\_\_\_\_ (Name of Child) to participate in  
Boomerang Health's *Virtual Anxiety Group*.

Please place a checkmark next to the statement(s) below that you are in agreement with:

- ☐ I am aware of that the group is being completed virtually and understand the inherent risks of virtual care;
- ☐ I agree that I have received information about the nature of the group and the expected outcomes;
- ☐ I am aware that a health record was created for my child and that all of his/her records are confidential;
- ☐ I have been informed about how to access Boomerang Health's privacy policy (on the website);
- ☐ I understand that Boomerang Health will not share any information about my child with outside parties (e.g. school, physician, community programs) without my written consent.

Name of Parent/Guardian: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Today's Date: \_\_\_\_\_

After each group session, an invoice will be provided for the session that you and your child attended. If a session was missed, we are not able to issue an invoice for that date. We can only issue invoices for services that have been rendered. Please initial to signify that you have read and understand this policy: \_\_\_\_\_

We may take photographs or videos as part of our group programming. These are typically used as during reflective exercises and will not be used outside of the group or shared with anyone else. Do you consent to Boomerang Health taking pictures/videos of you/your child?      Yes      No